

**WORKING LIFE DISCRIMINATION AMONG MIGRANT REGISTERED NURSES
IN HOSPITALS IN FINLAND: A PILOT STUDY**

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ABSTRACT

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Discrimination at the workplace is a major source of dissatisfaction among migrant nurses in other countries such as United Kingdom and Australia. Despite acknowledging the difficulty of retaining internationally educated nurses in Finland, there is a paucity of data concerning workplace discrimination of migrant registered nurses (RNs) in Finland.

The aim of this pilot study is to look at whether migrant RNs in hospitals and hospital-like settings in Finland experience workplace discrimination and if so, the nature of this discrimination. The purpose of this study is to inform health centres about issues that need to be addressed to ensure a discrimination-free workplace that is conducive to nurses of all ethnic and racial backgrounds.

Data were collected through semi-structured interviews and analysed using thematic analysis. The themes that emerged were sorted using Feagin and Eckberg's Typology of Discrimination. Discrimination can exist on the personal level (microlevel discrimination) and on the organizational level (macrolevel discrimination). The major component of

microlevel discrimination was microaggression, which can be broken down into microinsults, microinvalidations and microassaults. Barriers to language and communication, limited career opportunities and deskilling emerged under the macrolevel discrimination category.

This study shows workplace discrimination of RNs who have migrated to Finland on both the microlevel and macrolevel. It provides valuable insight on how migrant RNs experience discrimination in their working lives and what issues need to be addressed to rectify the problem. Eradicating discrimination at the workplace is a good way to retain nurses and ensure a healthy work environment for all.

Keywords: workplace discrimination, migrant registered nurses, Finland, job satisfaction

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ABBREVIATIONS & DEFINITIONS

Abbreviations

European Union

NHS National Health Service

P Participant

R Researcher

REOH Researching Equal Opportunities for Internationally Recruited Nurses and Other Health Professionals: Valuing and recognizing the talents of a diverse health workforce (REOH)

RN Registered Nurse

THL Terveystieteiden tutkimuskeskus ja Hyvinvoinnin Laitos

UK United Kingdom

USA United States of America

Definitions

Deskilling: occurs when integrated skills and comprehensive knowledge of the work being done is lost as work becomes more fragmented and the scope of work reduces drastically

Global North: economically developed countries of the world regardless of geographical location

Global South: countries that do not qualify for economically developed status regardless of geographical location

Registered Nurse: a nurse who has at least a bachelor's degree in nursing and has been authorised by Valvira to practice as a registered nurse

Valvira: National Supervisory Authority for Welfare and Health

1. INTRODUCTION

This pilot study examines the phenomena of workplace discrimination of the migrant Registered Nurse (RN) in Finland. Workplace discrimination of migrant nurses has been documented in the United Kingdom (UK) (Estacio & Saidy-Khan, 2014; Henry, 2007), Australia (Mapedzahama, Rudge, West, & Perron, 2012; Deegan & Simkin, 2010) and the United States of America (Baptiste, 2015). A recent study conducted by Pitkänen, Keisala and Niiranen (2017) acknowledged the challenge of retaining internationally educated nurses in Finland and addressed the need for intercultural work. However, studies that focus on workplace discrimination against migrant nurses in Finland are still rare.

Discrimination can take many forms. It can be overt in the form of racially aggressive statements or covert in the way of microaggression. Discrimination against migrant nurses can also be of a personal or professional nature. A sense of alienation and social exclusion at the workplace are forms of personal discrimination (Baptiste, 2015; Alexis & Vydelingam, 2004), while deskilling (O'Brien, 2017; Deegan & Simkin, 2010) and a lack of career opportunities (Henry, 2007; Alexis & Vydelingam, 2004) constitute discrimination of a professional nature. It can be carried out by individuals or done on an organisational scale through the implementation of policies and procedures (Feagin & Eckberg, 1980).

Discrimination at the workplace may lead to decreased job satisfaction (Shields & Price, 2002), which in turn is positively correlated to a higher desire to leave the profession (Flinkman, Laine, Leino-Kilpi, Hasselhorn & Salanterä, 2008).

In general, there are many reasons given about why nurses are dissatisfied and would like to leave the profession. Some of the reasons cited by Finnish nurses were low pay, unfavourable

working hours and the demanding nature of the job (Flinkman et al., 2008). In a literature review undertaken by Lu, While and Barriball (2005), nurses derived job satisfaction from positive working conditions, good relationships at work (patients, colleagues and managers), the work itself, remuneration, opportunities for self-growth and promotion, as well as the level of control and responsibility they wield at work. Job satisfaction is also related to what nurses expect from their job (Lorber & Savic, 2012). Other factors that influenced job satisfaction among nurses were age, years of experience, the personal characteristics and the managerial competency of nurse leaders (Lorber & Savic, 2012). The retention of nurses is inversely related to their job satisfaction (Coomber & Barriball, 2007).

On top of these given challenges and the reasons nurses are dissatisfied with their jobs, the migrant nurse also faces the additional burden of discrimination at the workplace.

Discrimination is based not only on race but also language and cultural characteristics. For minority nurses in the UK National Health Service (NHS), job satisfaction was closely tied to the level of racial harassment at the workplace (Shields & Price, 2002).

This study will focus on workplace discrimination as it is particular to migrant RNs in Finland.

2. LITERATURE REVIEW

The literature review focused on the key aspects of the study which were job satisfaction among RNs, discrimination at the workplace experienced by migrant RNs, and the theoretical framework used to interpret the data collected. 'Black' and 'White' are used to denote race, and as such, have been capitalised.

2.1 Job (dis)satisfaction among nurses

Job satisfaction among nurses depends on many factors. The nine facets of job satisfaction according to Spector's Job Satisfaction Survey (1985) were salary, the nature of the (nursing) job, working conditions, good relationships and communication at the workplace, appreciation and recognition, job supervision, and job security. Low levels of job and workplace satisfaction among nurses in Finland were positively correlated with a higher desire to leave the profession (Flinkman et al., 2008).

Low salary was the main reason nurses under 30 in Finland cited for wanting to leave the profession. Almost all nurses in the study agreed it was one of the top three reasons they were dissatisfied with their job (Flinkman et al., 2008). This was echoed by nurses in the UK NHS (Durand & Randhawa, 2002). Pay was cited as the second most important aspect of job satisfaction for nurses in Slovenian hospitals (Lorber & Savic, 2012). Low pay was one of the reasons British nurses decided not to go back to work after having a career break (Durand & Randhawa, 2002). This was confirmed by a literature review which corroborated that low salary was a main source of dissatisfaction among nurses and a factor when nurses considered leaving the profession (Goodare, 2017). Many nurses felt nursing should be better paid

considering the responsibilities involved and the demands it places on the nurse (Flinkman et al., 2008).

The nature of nursing should be considered when taking into account the satisfaction of nurses. Nursing has traditionally been a humane, caring profession with nurses caring for the emotional and psychological needs of patients alongside their physical needs. Today, nurses are seen as professionals who use technology and clinical evaluation to treat their patients (Scott, Matthews & Kirwan, 2014; Durand & Randhawa, 2002). Job satisfaction for nurses declined when they felt they were too busy to provide good quality care to their patients. The mental and physical aspects of nursing coupled with a lack of staff were the reasons cited for the erosion in the quality of care which left nurses dissatisfied. Nurses also reported feeling tired due to their irregular working hours and were dissatisfied with how their work shifts affected their own well-being (Flinkman et al., 2008). Physical manifestations of stress such as headaches, insomnia and back pain were reported by nurses as well as feelings of being emotionally exhausted at the end of the workday. These psychosomatic symptoms could ultimately lead to reduced job satisfaction (Schwendimann, Dhaini, Ausserhofer, Engberg & Zúñiga, 2016). Nurses were also generally dissatisfied with their working conditions. Shortage of staff was a major reason for this and was linked to inadequate patient care, increased work demands, stress (Flinkman et al., 2008) and even burnout (Flinkman et al., 2008; Schwendimann et al., 2016). Working conditions which demanded nurses to do three different shifts, including night shifts, but did not provide for daycare during these hours were seen as an obstacle to practice nursing, especially for nurses with young children (Durand & Randhawa, 2002). Inflexible working hours and lack of control over work schedules made it difficult for nurses to have a balanced work-family life (Flinkman et al., 2008). Good working conditions which contributed to nurses' job satisfaction included greater job control,

job autonomy (Lorber & Savic, 2012), a safe climate at the workplace, and involvement in decision-making (Swendimann et al., 2016).

Good relationships with colleagues and ease of communication at work positively contributed to nurses' job satisfaction. Communication was a key factor leading to job satisfaction. It also increased team spirit, which in turn led to higher job satisfaction. Disagreements between colleagues regarding patient care and conflicts with supervisors led to negative job satisfaction (Schwendimann et al., 2016). Support from colleagues was vital in ensuring that young, inexperienced nurses remained in the workforce (Flinkman et al., 2008). A literature review conducted by Lu et al. (2005) confirmed that group cohesion was positively correlated with job satisfaction at the workplace.

Appreciation and recognition were also found to positively contribute to job satisfaction. Praise from superiors and their encouragement were found to influence job satisfaction. Opportunities for promotion and education possibilities also affected job satisfaction positively (Lorber & Savic, 2012). Lack of opportunities for promotion led nurses to consider leaving the profession more often (Flinkman et al., 2008). Having skills that were not utilized made nurses feel unrecognized, which significantly and adversely affected their job satisfaction (Schwendimann et al., 2016). Nurses in the UK NHS felt, among other things, that showing appreciation for nurses would increase the chances of nurses returning to work after a career break (Durand and Randhawa, 2002).

Literature on job supervision and job satisfaction among nurses was sparse. However, when supervision was defined more broadly to include leadership style and organizational culture, it became apparent that it was closely linked to job satisfaction. Supportive leadership and resonant nursing home supervisors were found to contribute towards the job satisfaction of nurses. In fact, the most important environmental factor associated with job satisfaction was

leadership (Schwendimann et al., 2016). This was corroborated by Lorber and Savic (2012) who found that leadership style and personal characteristics of leaders influenced nurses' job satisfaction. They found that managerial capabilities had a big effect on nurses' job satisfaction.

The last among the nine factors studied to influence work satisfaction, according to Spector (1985) was job security. Job security could be measured by whether a nurse had a temporary or permanent work contract. Nurses who had temporary work contracts were more likely to consider leaving their workplace than nurses who had permanent contracts (Flinkman et al., 2016).

2.2 Workplace discrimination of migrant nurses

Discrimination at the workplace is not something foreign nurses consider when they migrate from the Global South to the Global North to start a nursing career and pursue their ambitions. Nevertheless, a common theme that emerged from Estacio and Saidy-Khan's study (2014) was that migrant nurses frequently faced discrimination in the form of denied opportunities for further career development based on racial and/or ethnic factors. Non-transparent policies and procedures for career advancements also led to perceived discriminatory behaviour (Henry, 2007). Migrant nurses came to the UK with expectations of being judged on meritocracy and expressed shock to be judged by the colour of their skin instead. Race-based discrimination was difficult to deal with and left them feeling frustrated and disillusioned (Alexis & Vydelingum, 2004).

Despite speaking the local language, migrant nurses still faced language and communication barriers in their host countries. In a professional context, clear, concise communication is a must for nurses to fulfill their roles and responsibilities. Nevertheless, medical terminology

and abbreviations might differ from country to country or even hospital to hospital. Accents and slang might vary even among nurses who share a common first language (Chege & Garon, 2010). The situation is exacerbated when nurses are required to convey multiple instructions in a limited time frame (for example, during a phone call or the handing over of one shift to the next). In a competency based assessment program for migrant nurses in Australia, native English-speaking nurses were found to speak too fast and not repeat themselves while blaming the migrant nurse for being stupid, thus undermining the professional integrity of the migrant nurse (Deegan & Simkin, 2010).

Social communication at the workplace (as opposed to professional communication of job-related information) is also rife with struggles for the migrant nurse. Language can be used as a subtle form of racism. The use of language and humour depends very much on the context. Taken out of context, nothing might seem amiss even though the damage has been done (Estacio & Saidy-Khan, 2014). To further complicate matters, communication also greatly depends on other non-verbal factors, such as body language, eye contact, tone of voice and emphasis on certain words, to name just a few, all of which may be very difficult to prove in cases of accusations of racism and discrimination (Estacio & Saidy-Khan, 2014; Deegan & Simkin, 2010; Sue et al., 2007a).

Deskilling of migrant nurses is another challenge that foreign nurses face in the Global North. Deskilling occurs when the scope of work is drastically reduced to just a few, or even one, task due to advances in technology or the division and specialization of labour. Workers lose integrated skills and comprehensive knowledge of the work being done as work becomes more fragmented (Online Dictionary of the Social Sciences, 2002). According to O'Brien (2017), for nurses to be deskilled, they need to be highly trained and hired to work in a specific and subordinate position. There seems to be a mismatch of the expectations of

recruiters in the UK and the migrant RNs from the Global South: migrant RNs from the Global South were expected to provide direct patient care in terms of hygiene provision on working in the UK. Most of the nurses from the Global South who filled these vacancies in the UK had a high level of technical skills and little practical experience in direct patient care (O'Brien, 2017). Migrant nurses were also dissatisfied with the clinical grade they fell into on migrating to the UK. They felt their past work experiences and education were not fully recognized and taken into account in the UK. The work they did was perceived as not being representative of their roles, responsibilities and experience as RNs (Buchan, Jobanputra, Gough & Hutt, 2006). However, due to racism and discrimination, these highly qualified foreign nurses were restricted to entry-level jobs in their new country with little or no prospects for advancement (O'Brien, 2017).

Other than deskilling and limited career options for progression, foreign nurses also experienced discrimination (due to race) and racist bullying. According to McNeilly et al. (as cited in Torres-Harding and Turner, 2014), racism contains behavioural and attitudinal components. The former manifests itself in discrimination while the latter includes beliefs of racial superiority. Verbal harassment resulting in discomfort and embarrassment are overt signs of bullying. Marginalization and social isolation are subtle or indirect forms of bullying and also an outcome of discrimination (Alexis & Vydelingum, 2004). Overt and subtle forms of bullying are further discussed in the framework section of this study. Verbal harassment demonstrates the behavioural component of racism while marginalization and social isolation could be due to its attitudinal elements. Migrant nurses often face racist discrimination daily as differences are seen as problems instead of diversity (Alexis & Vydelingum, 2004).

Finland provides a useful context to analyze the discrimination experienced by migrant nurses as communication and language related challenges are likely to be more pronounced

between migrant and local nurses than perhaps in an English-speaking country. English as a language is learnt in many schools worldwide whereas migrant nurses who move to Finland start learning Finnish from scratch as an adult. The reticence of Finns combined with their sense of personal space might also prove difficult for the foreign nurse to comprehend.

2.3 Framework: Feagin and Eckberg's Typology of Discrimination

Feagin and Eckberg (1980) attribute two distinct dimensions to discrimination, namely embeddedness and motivation, from which four basic types of discriminatory practices are uncovered. Embeddedness refers to “the organizational environment, to the size and complexity of the relevant social unit.” These social units may be large organizations, a small group of individuals or even a lone individual. Motivation for discrimination may be intentional or unintentional. Intentionally motivated discrimination is due to prejudice, conformity and gain. Unintentional discrimination occurs when there is neither motive nor intent to cause harm but which nevertheless could have harmful effects. The discriminatory practices that were uncovered using this model were divided into isolate discrimination (Type A), small group discrimination (Type B), direct institutional discrimination (Type C), and indirect institutional discrimination (Type D) (Feagin and Eckberg, 1980).

Isolate discrimination (Type A) occurs when a dominant-group individual, unsanctioned by any institution or organizational setting, intentionally goes about harming a member/members of a subordinate group (Feagin and Eckberg, 1980). Incidences of preference by patients or their family members for a domestic nurse as opposed to a migrant nurse (Mapedzahama et al., 2012), harassment of immigrant nurses by their White counterparts (Sue et. al., 2007a; Estacio & Saidy-Khan, 2014), and a lack of respect for professional migrant nurses by their

colleagues all fall into this category (Sue et. al., 2007a; Deegan & Simkin, 2010; Smith, Allan, Henry, Larsen & McIntosh, 2004).

Small group discrimination (Type B) consists of a small number of dominant-group individuals who go about causing intentional harm to a member/members of a subordinate group without the consent or sanction of others within the organizational structure (Feagin and Eckberg, 1980). It is similar to isolate discrimination except that it is perpetrated in a group instead of by an individual. Incidences of small-group discrimination against migrant nurses in nursing literature are documented as a feeling of 'otherness,' marginalization, and a sense of invisibility (Mapedzahama et al., 2012; Deegan & Simkins, 2010; Smith et al., 2006). A study conducted in Australia had Black African nurse participants describe “the prejudicial White gaze” which local nurses gave them, linking their appearance to the (underdeveloped) Global South and inferiority (Mapedzahama et al., 2012). Lateral violence among nurses where the migrant nurse is targeted for being foreign is another example of small group discrimination (Smith et al., 2006). Small group discrimination also often results in social exclusion and perceived pressure to conform to the social norms of the dominant group (Deegan & Simkin, 2010; Smith et al., 2006).

Direct institutional discrimination (Type C) occurs when an organization or community undertakes a course of action with the explicit intent of unfavourably affecting a subordinate group. This type of discrimination may arise due to formal or informal organizational rules and regulations or even through legislation. They are often enshrined in large bureaucracies as part of their standard operating procedure (Feagin and Eckberg, 1980). Wage discrimination of migrant nurses is an easily quantifiable discrimination of this sort, although there are other forms, too. In a study by Shields and Price (2002) conducted in the UK, almost 7% of migrant nurses reported being made to work overtime without being

sufficiently compensated for it. Another clear example of this sort of discrimination is “the discriminatory power of culture and language.” The use of buzzwords and professional discourse to demonstrate nursing skills in interviews for promotion left migrant nurses at a marked disadvantage. Migrant nurses were not familiar with these terms, even though they lacked nothing by way of clinical skills (Smith et al., 2006). Other forms of direct institutional discrimination are not so easy to prove. According to Smith et al. (2006) in the *Researching Equal Opportunities for Internationally Recruited Nurses and Other Health Professionals: Valuing and recognizing the talents of a diverse health workforce (REOH)* report, career advancement for nurses in the UK was not transparent, paving the way for intentional discrimination. This was especially so when the promotion was to a managerial position. A study by Henry (2007) confirmed this, as Black nurse participants felt they had been discriminated against for promotion and career advancement in the UK.

Indirect institutional discrimination (Type D) is when an organization or community, without prejudice or intent to harm, follows a course of action which nevertheless affects members of a subordinate group in an unfavourable way. This form of discrimination can be divided into past-in-present discrimination and side-effect discrimination. Past-in-present discrimination occurs when current procedures which seem neutral when taken superficially are actually based on intentionally discriminatory procedures of the past. The seeping of racist ideology into the British healthcare system (Allan, Larsen, Bryan and Smith, 2004) and the role it plays in the current devaluation of migrant nurses' skills and their exclusion from career progression (Allan & Larsen, 2003) is one example of past-in-present discrimination facing migrant nurses today. Side-effect discrimination occurs when procedures of an organization or institution have a negative effect due to its linkage to intentionally discriminatory procedures of another organization (Feagin and Eckberg, 1980). Reassigning a White nurse to a patient who has refused care from a (non-White) migrant nurse (Mapedzahama et al., 2012)

might be viewed by some as a form of side-effect discrimination. The only difference between direct and indirect institutional discrimination is the intent to cause harm. As such, when the intent of the given procedure is questionable, it may be hard to distinguish between direct and indirect institutional discrimination. Using the same example given above, the career progression (or lack thereof) of migrant nurses could be due to either direct or indirect institutional discrimination, depending on whether it was done deliberately or not.

Racism comes in two forms: overt and indirect (Smith et al., 2006), and these are also applicable within this framework. Overt discrimination is xenophobic, openly racist and includes strategies to cause harm or exclusion. Indirect racism is harder to define, as there may not be a conscious intent to harm or exclude. It is deeply ingrained into practices, culture, social structures, and the power relationships that go with it. While overt racism might be on the decline, a new form of indirect racism, called microaggression, is emerging. Sue et al. (2007a) define racial microaggression as “brief and commonplace daily verbal, behavioral or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults.” According to this theory, microaggression can further be broken down into three categories: explicitly racial derogation (microassaults), expressions of negativity towards another person's racial identity or heritage (microinsults), and invalidation of another person's thoughts, feelings, and experiences in relation to racial or ethnic identity (microinvalidation.) Responding to microaggression is problematic. It might make the victim seem 'paranoid' or having 'some major personal problem'. Furthermore, non-response could lead to severe conflict in the victim (Sue, Bucci, Lin, Nadal & Torino, 2007b; Wang, Leu & Shoda, 2011).

Microaggression is a serious problem and has been linked to chronic illness (Gee, Spencer, Chen & Takeuchi, 2007) and mental health problems (Borrell, Kiefe, Williams, Diez-Roux & Gordon-Larsen, 2006).

3. RESEARCH QUESTIONS

There are shared issues on workplace satisfaction between local and migrant nurses.

However, discrimination at the workplace in Finland due to race and ethnicity is something the local Finnish nurse is exempt from. The aim of this study is to determine whether migrant RNs of colour experience discrimination at the workplace and if so, what kind of discrimination they experience.

The purpose of this study is to inform hospitals and health centres so they are aware of the issues that need to be addressed and the questions that need to be asked in order to overcome discrimination at the workplace. By increasing workplace satisfaction, nurses are more likely to stay in their jobs. The long-term goal is to ensure a nursing workplace that is adequate in size and skill to meet the future needs of caring for Finland's population.

The research questions are:

- 1.) Is there discrimination against migrant RNs of colour in hospitals and hospital-like healthcare settings in Finland?
- 2.) What types of discrimination exist in these settings?

4. MATERIALS AND METHOD

This section will deal with the details of data collection and analysis. The method chosen for data analysis will be explained as well as the analysis of the data. The strengths and limitations of the data will be discussed. The section closes with a brief look at the ethical considerations relevant to this study.

4.1 Data collection

The initial research question was to study the well-being of migrant RNs in Finland. The approach was to conduct semi-structured interviews with migrant RNs of colour. In total, six female RNs from five towns and cities in Finland were interviewed for this study. The RNs interviewed worked in Tampere, Helsinki, Espoo, Kirkkonummi, and Hämeenlinna. The interviews took place in Tampere, Helsinki and Espoo. All the RNs worked in hospitals or hospital-like healthcare centres. Half the participants were known to the lead author prior to the study. The other half were obtained through the use of snowball method of sampling. All interviews were conducted by the author.

Data were collected from participants of African and Asian descent to ensure the perceptions of workplace discrimination were from a non-White perspective. Studies show that people of colour experience racism and discrimination differently than Whites (Jones as cited in Sue et al., 2007a). Asian and African migrant nurses in Finland found their experiences at the workplace different than their White counterparts from Estonia or Russia (Terveyden ja Hyvinvoinnin Laitos [THL], 2013).

In-depth, semi-structured questions were used. The researcher had a checklist of items to cover, but participants were allowed to talk freely about their experiences. Open-ended questions were asked to allow the participants to answer in their own words and elaborate if they felt it necessary. All the items on the checklist were covered for each interview. This form of interview was chosen as it allows for fluidity when conducting the interview. It also allows the researcher to respond to topics raised by the participant which might not be on the checklist. The questions covered a variety of lifestyle issues, including elements relevant to the discrimination typology. The interview covered both the professional and social aspects of being a female migrant RN in Finland. The interviews lasted from between 90 and 120 minutes.

Interviews were transcribed even as new interviews were scheduled to take place. After the initial analysis of three interviews, it was decided that the scope of the study be narrowed down to workplace discrimination of migrant RNs. Workplace issues formed a major part of the interviews that had been conducted, and the data collected were sufficient for this narrower focus. Further interviews were then limited to focusing on social and professional issues that arose at the workplace. These later interviews lasted from between 45 to 90 minutes.

The interview was conducted at a place of the participant's choosing. The interview was started by asking simple questions about the participant such as her age and the number of years she had been in Finland. It then progressed to asking the participant how she found life in Finland. This led to covering the social as well as professional aspects of life in Finland as seen from a migrant's perspective.

The inclusion criteria for participants included that they had at least one university degree from their country of origin or the host country. In practice, it turned out that all the RNs interviewed had had their nursing education in Finland. All had done some of their practical placements locally, thus exhibiting a certain mastery of the Finnish language. Another inclusion criteria was that the participants had lived in Finland for a minimum of three years. In practice, because all the RNs received their nursing education in Finland, all had lived in Finland for more than the minimum time stipulated in the inclusion criteria. Due to dual citizenship and also the freedom to travel and migrate offered by Finnish citizenship, a number of study participants held Finnish passports. However, all study participants were born and raised outside Finland.

Table 1 provides the basic information of the RNs who took part in this pilot study.

Table 1. Basic characteristics of respondents

	AGE	COUNTRY	YEARS IN FINLAND	YEARS OF PROFESSIONAL EXPERIENCE
NURSE A	30	China	11	5
NURSE B	37	Kenya	17	13
NURSE C	49	Zambia	13	19
NURSE D	23	Nigeria	6	3
NURSE E	29	Kenya	9	6
NURSE F	30	China	7	3

4.2 Method of Data Analysis

The data collected were transcribed and analysed using thematic analysis. Thematic analysis was chosen for two reasons. First, it is a tool for “identifying, analysing and reporting patterns or themes within data” (Boyatzis as cited in Braun and Clarke, 2006). The transcribed data showed repeating patterns and themes. Second, thematic analysis examines the meaning of what the participant is saying and seeks to understand the social reality of the participant (Zhang & Wildemuth, 2005). Since the study deals with migrant RNs and their perceptions of their workplace and discrimination, and the data gathered showed recurring themes when transcribed, thematic analysis was chosen to analyse the data.

Thematic analyses can be undertaken in a number of ways. An inductive approach is taken when the coding and the themes developed are focused on the data and their content. The data are coded without a pre-existing framework. A deductive approach is more analyst-driven and is in line with the researcher's preconceived ideas and concepts. It provides a more detailed view on the aspect of analysis the researcher has decided to focus on. Data can also be coded semantically where the codes and themes are in accordance with the explicit meaning of the words and sentences in the data. No meaning is given to anything not explicitly expressed by the participant. A latent approach is when concepts and assumptions behind the data are used in the coding and development of themes in said data. Thus the themes that are produced are already theorized and are not merely descriptive as interpretative work has been done in the development of these themes. This form of thematic analyses overlaps with discourse analysis. Thematic analyses, that reports an inferred reality that is obvious from the data, is a realist or an essentialist approach. A constructionist approach, by contrast, focuses on how a particular reality is formed or constructed by the data

(Braun & Clarke, 2006). The thematic analyses approach used here was inductive, semantic and realist.

The first step in doing thematic analyses is to familiarise oneself with the data. The author was familiar with the data as all stages of data collection and transcription was done by the author herself. Interviews were transcribed verbatim with appropriate non-verbal gestures included (such as shaking of the head, sighing, laughing, etc.) In this way, the author attempted to maintain the accuracy of the verbal and non-verbal story being told as it was intended in its original form.

Data were transcribed using Express Scribe Transcription Software. The transcribed interview was copied into OpenOffice Writer for the analysis stage. The final transcribed data of 79 pages were read and re-read to highlight issues that were raised by the participants. The entire data set was then coded manually by the author. Each participant was assigned a text colour to make it easier to know who had said what without revealing the identity of the participant. Numbers were also assigned to the lines of text so the data could be referred to in the context in which it was said. The colours and the numbers made it possible for the text to be referred to its original source with ease. Some sentences contained more than one code. Data were copied from the original transcribed files and pasted onto a new page and code(s) were assigned to the sentence(s). At the end of this stage, all the sentences were grouped together under their respective code(s).

The next phase consisted of searching for themes from the coded data. Data that did not pertain to work were excluded at this point. A new document was opened and the whole data set was copied and pasted there to be sorted into preliminary themes.

The 10 broad themes that emerged from the interviews were:

- discrimination
- future in Finland
- satisfaction and motivation
- language barrier
- stress
- social cohesion
- health and vitality
- working conditions
- appreciation and recognition
- cultural differences

The theoretical framework used to anchor the analysis was Feagin and Eckberg's Typology of Discrimination (1980). Isolate discrimination and small group discrimination were categorized as microlevel discrimination, while direct institutionalized discrimination and indirect institutionalized discrimination were categorized as macrolevel discrimination. Microaggression was the major theme that emerged in the microlevel discrimination section. Microaggression was further divided into microinsults, microinvalidations and microassaults. Barriers to language and communication, limited career opportunities, and deskilling emerged under the macrolevel discrimination category.

4.3 Strengths and Limitations

A major strength of this study is that migrant RNs were able to express how they felt about their workplace and their work experiences in Finland in their own words. The study was conducted in English, a language of proficiency for both the participants and the researcher. The participants were able to express themselves clearly and be understood.

Misunderstandings and the loss of nuances through translating were thus avoided. Sending the transcripts to the participants further allowed them to ensure the data had been correctly understood and transcribed.

Having a face-to-face interview allowed the researcher to develop a rapport with the participants, making it easier for them to open up about their experiences in the workplace. The author sharing a professional background with the participants also created affinity between researcher and participant. Letting the participants decide on the venue for the meeting helped set the participants at ease.

The use of a semi-structured interview was a strength in this study as it allowed the researcher to cover all the areas necessary to gather the needed information while allowing for flexibility. The flexibility offered by semi-structured interviews allowed the researcher to adjust the flow of the interview according to the lead of the participant. The participants were able to share as much or as little as they felt comfortable. Nevertheless, all the topics on the checklist were covered satisfactorily.

One of the major limitations of this study is the fact that the sample size is rather small, being a total of six. Furthermore, half of the participants were known to the researcher. While this might seem like a selection bias to some, the prior affiliation allowed a certain amount of trust between researcher and participant which was vital for gaining in-depth information of a

sensitive nature. This trust was also vital when the snowball method of sampling was used to collect data from participants unknown to the researcher. One participant was nevertheless still rather apprehensive about opening up, again highlighting the importance of trust and rapport in the process of collecting data of a sensitive nature. Furthermore, it was not easy to find random migrant RNs who wanted to participate and share their views on working life and whether they had experienced discrimination at the workplace. Lastly, this being a pilot study, further research needs to be conducted in the area to determine transferability and extrapolation of data to a wider population.

4.4 Ethical Considerations

Study participants were informed verbally of the purpose of the interview. No approval from any ethical committee was needed as the RNs were interviewed during their free time. A mobile phone was used to record the interviews, and the participants were aware the interview was being recorded. A written transcript of the interview was sent to each study participant to ensure they were aware of what had been recorded and transcribed.

Confidentiality was kept by assigning a colour code for each study participant. No last names were used during the whole recording and transcription process, thus keeping a degree of anonymity. Names of hospitals and work places were not used in the final study to further protect the anonymity of the participants.

5. RESULTS

This chapter delves into the findings of the study about how migrant RNs of colour experience their worklife in Finland. The results obtained on job satisfaction will be broken into Spector's (1985) nine facets of job satisfaction. Each of these facets are presented below in bold with relevant quotes to support them. Discrimination will be identified according to Feagin and Eckberg's Typology of Discrimination. Quotations of conversations from the interviews will be used to share the thoughts and feelings of the RNs. Where a section of the interview involves the dialogue between researcher and participant, R is used to denote the researcher and P is used for the participant.

This chapter consists of job and workplace (dis)satisfaction, the theoretical framework used in the study, microlevel discrimination, and macrolevel discrimination. Microlevel discrimination manifests itself as microaggression. Microaggression can be further broken down into microinsults, microinvalidations and microassaults. Macrolevel discriminatory factors that were brought to light in the interviews were the use of language and communication as a form of discrimination, lack of career opportunities, and deskilling.

5. 1. Job and workplace (dis)satisfaction

As mentioned earlier, the **nine facets of job satisfaction** according to Spector (1985) are salary, the nature of the (nursing) job, working conditions, good relationships and

communication at the workplace, appreciation and recognition, job supervision and job security.

Contrary to the findings stated above (Flinkman et al., 2008; Lorber & Savic, 2012; Durand & Randhawa, 2002; Goodare, 2017), the issue of **salary** was not mentioned by most of the RNs interviewed. Only two RNs brought it up in passing, with Nurse D and Nurse E saying their salary was 'okay'. Nurse D said she was '*satisfied*' with her salary while Nurse E said she could '*survive with it*'.

As for the **nature of nursing**, Nurse B described it as “*very stressful for even Finnish nurses, not only foreign nurses.*” She continued:

Those days I spent my whole night thinking about who I'm going to work with tomorrow in theatre. And the work is also so that you have to concentrate on those surgeries.

They are long surgeries and then they are changing us in the theatres. You are going tomorrow to vascular, tomorrow you're going to gastroenterology, the other day you're going to pediatric surgery. Your head has to be sharp all the time. And then you have to take stress about who you're going to work with ---- it was too much!

It was not just the mental aspects of nursing that was stressful but it could also be physically demanding.

I can't even work in the wards anymore because of my back. I would love to go back and learn again my ward work but I can't because I can't lift anymore so much. I'm not physically lifting patients (now), whereas in the ward, you're doing that 24/7 or the number of hours you're working. Then I'm gonna go down very fast. (Nurse C)

Nevertheless, the younger RNs expressed satisfaction concerning the nature of their work in that they got to help their patients.

And the fact that I get to help people. The nurse in me, I find satisfaction in that.

(Nurse E)

I think as nurses we are supposed to make the most uncomfortable person feel more comfortable. Like when they're in pain, you have to understand how much pain they're going through and know how much medication you're going to give to them. I think we have a really big impact on the society at large. You should be kind and very empathetic. I do this currently (at work). (Nurse D)

When it came to the **working conditions** in Finland, the RNs expressed mixed feelings.

Among those who were stressed at work, each experienced it differently, from frustration of not being properly supported at work to the more common complain of nurses working unsociable hours (Flinkman et al., 2008).

Certain times with the shifts, it could be stressful especially when you have, for example, 7 days of work and then you have maybe 2 days off or sometimes they give you like 5 days of work and 1 day off and then 6 days of work. It can be stressful. And also going from evening shifts to morning shifts, having lack of sleep and all that is stressful. I wish it could be a little better. Sometimes I do wish that I could work only Mondays to Fridays like normal people and do a certain shift and that's it. (Nurse D)

We've had for a very long time, almost 2 years, without a ward doctor. I feel like as a RN, I don't have that (someone to) support me in my work. It's really frustrating for me. That's the thing I have to say, I really hate about my job at the moment. (Nurse E)

Sometimes stress at work also manifested itself physically.

But the environment has been psychologically difficult. There's a time I started having these arrhythmias and when I went to the doctors, they found out it was stress related. I was really too stressed at work. (Nurse B)

Other RNs felt the working conditions in Finland were better than those in other countries.

But in Finland, it's actually good, you don't have so much screaming, shouting nurses and doctors because if you work in England, you'll be crying. You'll be working and crying. And you might end up being relieved because you become so emotional, that you can't do your job, you have to be relieved and go to the coffee room. It's even possible you go home because you can't work after that. (Nurse C)

Where I came from, you can see patients in discomfort and the nurses are still very mean and very bitchy to them. For example, a pregnant woman who is in labour, they can be very rude to her. But I don't think that is possible in Finland. I appreciate that a lot. (Nurse D)

Good relationships with colleagues and **good communication** are very important aspects of job satisfaction at the workplace. Most RNs had both good and bad experiences at the workplace. Some had had excellent mentors who supported them and taught them to become the skilled RNs they are today.

And the lady that coached me to do the clinical, she trained me, she was a brilliant lady, the best ever to work with. We had fun, the workers were good and ya, the doctors, even with the patients, I had no problem. We were really having a good time.

(Nurse C)

The years I was at work, my workmates have all been very supportive and helpful and they trusted me to do things and so I trusted myself. I have much confidence because of them. (Nurse A)

Constructive criticism and the honesty in negative feedback by colleagues were appreciated by the younger RNs.

Someone can tell you like, "OK, this you're not doing it right. Can you try and do it better?" I've never personally experienced it but I've seen the situations where it has been handled and I think it has been handled quite well at my work place. And that's a positive thing. (Nurse D)

(on negative feedback) I think it's a good thing. I make a mistake, tell me the mistake straight to my face. So the next day, I'll correct it. (Nurse E)

Some felt there was bickering and an unpleasant atmosphere at work though they saw it as nothing personal.

And it's not like they talk about you, foreigners, because they talk about each other as well. So there is this rivalry, one walks in, one talks about the other one, the other one goes, the others start talking about the one that has left. That was a vicious circle, so imagine a place like that for a foreigner, what is done. (Nurse C)

Some (colleagues) are good and some are badbut I have to say the atmosphere is not so friendly. Not hostile. But it's somewhat between hostile and unfriendly. (Nurse E)

Despite her positive professional experience at the workplace, Nurse A still felt a bit of an outsider.

I'm not able to actually establish a friend circle with Finnish people in here like how I could be able to do if I was in my native country.

As Nurse D succinctly put it:

Work is work. Friends are friends. That's the culture. That's how it is basically.

On the topic of **appreciation** and **recognition**, the RNs interviewed found appreciation and recognition for their work from many different sources.

Once a doctor gave me feedback. She actually gave my boss the feedback about me that she is a very good nurse. She is concentrating so much when she is doing her work. She liked when I assisted her in a surgery, so she gave feedback to my boss. Those kinds of feedback make me feel good. (Nurse B)

At work, with my boss, I feel really accepted and appreciated. But with my colleagues, it's a different thing. Like, not really appreciated. (Nurse E)

When asked what she found most rewarding about nursing, Nurse C replied:

It's having patients satisfied. I've had lots of recommendation letters written to my boss' boss who sent the mail over and they read it in the meeting of what the patient had said, had said thank you to me.

However, when it came to being recognized professionally and in monetary terms, the RNs expressed disappointment.

Professionally, my life in Finland hasn't progressed as I was expecting. Yes, I love nursing. But careerwise, I've been disappointed. (Nurse B)

I'm very good but I'm not good enough to qualify for the job. I am good and very experienced and I have all the professional know-how but they won't hire me. They will hire a (White, Finnish) undergraduate who doesn't even know how to work. They will teach that person, but not hire me. (Nurse C)

Job supervision and organizational structure did not come up much in the course of the interviews. Nurse C mentioned weak leadership by head nurses, who were also bullied by some of the other nurses.

The boss, they (the nurses) talked about the bosses, they didn't care. The boss has ended up changing places because it was impossible.

Unofficial supervision by colleagues who were looking for something to complain about was mentioned by two RNs.

What I remember is, they were looking if I do something negative. That's what they were concentrating on. (Nurse B)

They were really adamant on checking when I can fail my work. So eventually people started taking that up. (Nurse C)

Job security was not mentioned by any of the RNs unless it came up in conjunction with the visa application process.

Because I feel like I worry so much about my career, about my residency. If I would be in a better position with my career, I don't have to worry too much. (Nurse D)

Work situation is related to the visa. I need to go to apply so the work situation is a little bit stress me out. (Nurse F)

Overall, all the RNs interviewed had a philosophical attitude towards life and work which helped contribute towards job satisfaction even if they expressed dissatisfaction in certain facets of their working lives.

The work I did as a nurse was very, very meaningful. (Nurse A)

I feel, like, if I can't make it in Finland, I can make it somewhere else. I'm getting a lot of experience knowing how to do those surgeries and how to deal with different kinds of surgical treatments that they're offering here. So that's something I'm happy about. (Nurse B)

Work gives me satisfaction. To have a job, to be able to wake up every day in the morning, stay healthy, go to work and come back. That's all I need. (Nurse C)

The reward I get is making somebody else feel better about themselves. And making somebody else enjoy something they wouldn't be able to enjoy by themselves. For example, many of the patients I take out, they cannot take themselves outside. So them going outside makes me feel rewarded because they're satisfied about it. Focus on the positive things and ignore the negative things basically. And that's how I get through my day. (Nurse D)

The fact that maybe I can make someone else smile. That's a big thing for me. So every time I get to put a smile on someone's face, I find satisfaction. (Nurse E)

No matter where I will work, I just focus on it and do my best. If I get lonely, I will try to think how I can develop my work, improve my skills. (Nurse F)

5.2. Results in Discrimination

The results obtained from the data on discrimination were put into a table to see how applicable the Typology of Discrimination was to the data on the whole.

Table 2: RNs' experiences of the different types of discrimination

	TYPOLOGY OF DISCRIMINATION			
	MICROLEVEL DISCRIMINATION		MACROLEVEL DISCRIMINATION	
	TYPE A (isolate)	TYPE B (small group)	TYPE C (direct institutional)	TYPE D (indirect institutional)
NURSE A	-	-	-	X
NURSE B	X	X	-	X
NURSE C	X	X	X	X
NURSE D	X	X	X	X
NURSE E	X	X	-	X
NURSE F	-	-	-	X

All Black RNs experienced both Type A and Type B discrimination under microlevel discrimination.

Type C discrimination was experienced by only two RNs, making it the least common form of discrimination experienced. They were also the only two RNs to experience the full range of discrimination as described in the Typology of Discrimination. Type C discrimination was the most difficult form of discrimination to verify as it required one to prove that the entire staff or management at the hospital or healthcare centre undertook the course of action with the explicit intent of causing harm to the nurse.

Type D or indirect institutional discrimination was experienced by all the migrant RNs who participated in the study. All felt they had been adversely affected as migrants by rules and policies which were in place and on the surface appeared neutral.

Two RNs from the same town/city did not experience any form of personal or intentional discrimination. These two nurses were the only RNs of Asian origin and also the only ones to work in the capital city of Helsinki. This raises the question as to whether it was their race or the fact that they worked in the capital city that gave rise to their experiences.

5.3 Microlevel discrimination

While the nine facets of job satisfaction by Spector (1985) helped identify the different aspects of their job that workers value, it did not take into account an important factor for job satisfaction in a non-homogenous work environment, and that was discrimination. Frequent racial harassment from colleagues has been shown to have the largest adverse effect on job satisfaction among minority nurses. Racial harassment from patients also contributed to negative job satisfaction among these nurses (Shields & Price, 2002).

In this study, discrimination from colleagues and patients towards migrant RNs were categorised under microlevel discrimination. Microaggression constituted the major component of microlevel discrimination. Microaggression was faced by every Black nurse interviewed, the only difference being one of severity. Nurse C even resigned from her previous job in Finland due to microaggression.

I told my boss, I'm going to quit. So I resigned my job because of that person.

5.3.1. Microinsults

Microinsults express antagonism towards another person's racial identity, culture and customs. It is marked by rudeness and insensitivity and is meant to be demeaning. Subtle snubs and non-verbal cues could also be considered microinsults. When dealing with microinsults, context is critical. Microinsults may not seem like an aggression to a person of the dominant culture but the migrant/minority might perceive it as such due to its repeated usage coupled with negative action (Sue et al., 2007a). Migrant nurses interviewed experienced microinsults on a social as well as on a professional level.

And I remember my first day I started in Hospital Z. I was making a cup of tea and another nurse said, "Oh! You're that new nurse here. Well there is a Black girl that's going to be your friend but she's at the moment on maternity leave, so wait for her when she comes back. She could be your friend. I am here to work with you but don't expect me to be your friend. (Nurse C)

Finnish people like to say, "In Finland we do it this way. In Finland we do it that way." It makes you feel like, even more like, "OK so the way you're doing it in your own country is not the best." (Nurse B)

On the professional level, migrant RNs felt their expertise and skills were not considered equal to their Finnish counterparts despite having undergone the same education syllabus in the same country. Race and ethnicity seemed to overshadow the qualifications of these migrant RNs who were educated in Finland. Even though migrant RNs were officially recognised as RNs, they often experienced their professionalism and skills being called into question by doctors, colleagues and even student nurses.

And some (doctors), when they come in and see just a foreign nurse, they will ask you, "Are there any Finnish nurses in here? Who is in here? Or they say, "Is there anybody else apart from you?" (Nurse C)

Even some surgeons, some doctors, were very undermining. Not all of them. But there were some who really undermined you as a foreigner. Like they think you don't know what to do. Some of them will ask you some questions like you know --- that make you wonder! (laughs and shakes her head) (Nurse B) ´

At work, we have only four RNs in four wards. I happen to be the only Black foreign person. And sometimes the practical nurses have something they need to ask but I don't know is it because of my race or what, maybe they feel like I'm not competent enough, they go to some other person and they ask this other person. (Nurse E)

I taught a few student nurses to scrub for certain cases. Some you can teach, some you are teaching them, they don't know what to do and they are asking you but with a lot of ego and anger because they're intimidated that what they think a lesser person is teaching them. (Nurse C)

One nurse was even made to feel she only got her job because of her race and ethnicity and not due to her qualifications or skills, implying positive discrimination of foreigners.

Since I had permanent (position) and they didn't, they felt they deserved that position more than me. I heard them talking and one of them said, "Oh! Maybe they (the employees) just gave her that position because they're trying to show that this work place is very international." (Nurse B)

5.3.2. Microinvalidations

While microinsults express antagonism towards the victim, microinvalidations operate by making the victim feel invisible. It invalidates the experiences of the victim.

Microinvalidations are defined by Sue et al. (2007a) as communication that shows signs of exclusion, negation or the nullification of 'the psychological thoughts, feelings and experiential reality of a person of colour.' Nurse B experienced this first-hand when trying to join in the conversation around the coffee table during coffee break.

As a foreigner, nobody's listening to you. So you just end up going along with what they're saying. That's how I've felt. Sometimes I've ended up being quiet rather than speaking my mind. (Nurse B)

Colleagues are not the only ones who ignore the lived experiences of the migrant nurse. Head nurses who were aware of problems concerning group dynamics may not want to face up to the racial element of the problem. As Nurse C explained, the only 'help' she got from her head nurse on how to handle colleagues who were racist was to "stand up" for herself.

My colleagues went and reported her to my boss, that she's being mean and racist in her ways, so my boss called me. We started talking and I remember I just broke down. My boss told me to stand up on my own. (Nurse C)

5.3.3. Microassaults

Compared to microinsults and microinvalidations, microassaults are the most aggressive form of microaggression (Sue et al., 2007a). Microassaults take the form of overt racism and may be verbal or non-verbal in nature. They are conscious and deliberate attempts to cause harm to the victim, be it mentally or emotionally. They are generally carried out on a one-to-one basis or without a big group being present (Sue et al., 2007a). Microassaults in the form of racially derogatory statements could technically lead to criminal charges being filed in Finland (Non-discrimination Act 1325/2014).

Despite laws in place to prevent discrimination, migrant RNs noticed a marked difference in the way they were treated compared to local nurses and attributed it to their race and ethnicity. Attempts were made by some to willfully ostracize the migrant nurse. Efforts on the part of the migrant RN to be polite and try to fit in were not reciprocated.

They (the older nurses) will take her (a new White Finnish nurse) in faster than you.

You see that they're involving her. You see that acceptance. She will get along. I think it's that Finnish people just don't want to accept foreigners or involve them or maybe they don't trust foreigners. (Nurse B)

Some of them are very nice, the young ones (nurses) especially. I get along better with the young ones but the ones who are older we don't get along well because I feel like they're kinda intimidating me somehow. (Nurse D)

They'll (the local nurses) say 'Hi' and 'Good morning' to somebody but they don't answer you. You get the picture. Some people you work with for over 2 years, they've

never opened their mouth to say good morning. But if you say good morning, they'll answer or one day they don't bother. They've heard you quite right but they will not say good morning. (Nurse C)

Newer nurses trusted the established hierarchy of power and conformed to it, further consolidating the inherent racism in the social structure at the workplace. Others were bullied into submission.

They (the newer nurses) would rather listen to the other Finnish person than you. You see that they ignore you. A new nurse would come in the room, finding you there with the other nurse, you will see her pointing to that Finnish person asking that thing, not you. (Nurse B)

They (the old nurses) tend to group together and even the new nurses that come, they give them an ultimatum, if they were nice, friendly; the young ones are usually friendly. They would tell them, "If you want to belong to that group, eh! You choose to belong to that group and we gonna be mean to you." (Nurse C)

Microassaults also took non-verbal forms. Racial harassment and bullying were consciously employed to cause mental stress for the migrant nurse.

There was a lot of bullying, intimidating. They tried to intimidate you to the point of inflicting fear and making you feel like shit. They wanted to make you feel really like you are nothing. You have no brains. You are there for someone to tell you, "Do this. Do that." (Nurse C)

5.4. Macrolevel discrimination

Having looked at microlevel discrimination, which deals with discrimination perpetuated by individuals, we now turn towards organizational and structural level discrimination, or macrolevel discrimination. The data on macrolevel discrimination will be analysed under the headings of language and communication barriers, lack of career opportunities, and deskilling.

5.4.1. Language and communication barriers

Communication among nurses in hospitals consist of the professional exchange of information as well as everyday social communications. According to Nurse B, some people were already prejudiced about her capacity to speak Finnish even before she opened her mouth.

What I've noticed is that, though I know myself that I speak really good Finnish, but what I've noticed that with some Finnish people, they have this attitude, or this feeling that foreigners can't speak good Finnish, so in the beginning before they speak, before you go further in the conversation, they will kind of show you that they doubt that you can speak properly their language.

Communicating with her Finnish colleagues was even harder as Nurse B felt she was always looked down upon because Finnish was not her mother tongue.

I speak good Finnish but still they don't recognise that. They feel like you don't speak so good Finnish. The fact that they fluently speak their language, they feel that they're much better than you.

When asked about social communication at the workplace, Nurse B answered: *That's (pause) at my work place, it has been (pause) (big sigh) oh god! (laughs)*

Nurse A, who rated her Finnish skills as 'good', nevertheless said that it was “*very hard for me to improve my Finnish into a native speaker's level*”. She felt this was the level of Finnish expected from foreigners and when asked if this was possible, answered “*I wonder! (laughs) I doubt it!*”

Nurse C said that despite working every day in an environment where only Finnish was spoken, and despite having proven herself at work, she was still accused of not being able to speak or understand Finnish.

Their opinion is that I cannot speak Finnish (laughs). Or I'm not good in my Finnish. If I don't understand Finnish, how the heck did I read the patient reports to prepare for the cases that I'm doing? How did I listen to the doctor in the operation theatre if they want something if I don't understand Finnish? How did I work because I prepared the (operation) room by myself sometimes. I have to open the computer and read what case I'm doing. And the doctor puts there the information of the things he wants, if he wants something extra in the operation. I read the anaesthetic information. If it's gonna be difficult, what to go and get for the anaesthetic nurse to help her. I have to prepare the table. I have to prepare everything. So if I cannot read or write or understand Finnish (laughs), how the hell did I manage to read that and prepare for the case?

For Nurse E, the only mode of communication between her colleagues and her were of a professional nature. Social pleasantries and friendly small-talk around the coffee-table did not exist in her professional life as a nurse.

I'm here to be professional. If you're not professional, that's your problem. On my side, I will try to be as professional as possible. So that's how I get along with them.

Language and communication barriers were a major reason Nurse A was “*considering moving abroad*” and “*trying to look for a job from some English-speaking countries*”

5.4.2. Lack of career opportunities

Career opportunities for the migrant RN in Finland seem limited. Most RNs complained of being frustrated in the same job with no opportunities for promotion or further development of skills. Nurse F answered the question of career opportunities very diplomatically:

Definitely for foreigners they're quite (pause) quite (pause) maybe it's (pause) not too much.

Others were more vocal in their views:

The one challenge I know I have is like I'm really scared about my professional development, my growth. I feel like in Finland I'm a RN and that's just it. If I want something bigger, I have to go back to school and after school, I will just be maybe a osastonhoitaja (head nurse) and that's it. Like there's no, there's no these big opportunities for me as a foreigner in Finland. Like it's (sigh) (pause) I feel like my opportunities are very limited. Very limited. (Nurse E)

I've been working in the (operating) theatre for like over 10 years. I will be on the same level forever. It's not gonna change. (Nurse B)

For Nurse C, who has close to 20 years work experience in the operating theatre, mentoring final year nursing students and being in charge of ordering the equipment needed in the operating theatre are “career opportunities” she takes to heart.

At work, I've broken the barrier, I'm in charge of gastro orders and I'm now having students, which I had in Hospital Z but they didn't even trust you to teach a student. (laughs) They'll give you a first year student who's never been in theatre to show and they say, " Just show the basic." But now I've had a student who's graduating. I've taught her and the student has given very good feedback.

She does not see any real career opportunities by way of promotion save these added responsibilities to her workload.

R. How do you see yourself in 5 years time, in the workplace, in Finland?

P. (laughs) I'll be still exactly where I am. (laughs again)

R. So in 10 years time do you see yourself being promoted, being ...?

P. Promotion?! Never!!

Lack of career opportunities were linked to difficulties in skill development. Lack of career opportunities for the migrant RN were not only seen as an existing problem, but also a problem that extended into the foreseeable future.

5.4.3. Deskilling

While lack of career opportunities and development of skills were a stagnation to the RN, deskilling was a step back from what a RN can and should be able to do. Deskilling occurs when integrated skills and comprehensive knowledge of the work being done is lost as work becomes more fragmented and the scope of work reduces drastically (Online Dictionary of the Social Sciences, 2002).

Deskilling is another reason migrant RNs do not wish to stay on in Finland. Despite being a qualified RN, Nurse D basically works as a practical nurse. Even though there was a vacancy for a RN in her workplace, the job was filled by a temporary worker.

I have been asking my boss when I am going to start doing a sairaanhoitaja (RN's) work. And they keep coming up with stories and recently I noticed that somebody else is doing the job, like, from nowhere.

She worries about not gaining experience in the nursing field despite having graduated a few years ago.

Time is going and I'm acquiring experiences that I probably wouldn't use in the future. I would use them but I mean, I do basic care, how can I use that (as a RN)?

Nurse E fears she is not acquiring new skills and with time, she might be deskilled.

I've worked in that same place for 5 years now. So there's no new challenge for me at my workplace. At the moment, I say that my development skills at my work place are zero. I would love to move to some other place where I get new challenges and improve

my professionalism. But the fact that I feel like my skills are really limited, it makes me want to run away from this country.

Deskilling could lead to further difficulties in career opportunities for the migrant RN in an environment where career opportunities were already difficult to come by.

6. DISCUSSION

This study set out to find whether migrant RNs in Finland experienced discrimination at the workplace, and if they did, what kind of discrimination they experienced. The job satisfaction of these nurses were also taken into account using Spector's (1985) model of the nine facets of job satisfaction. This was done to determine whether the RNs were satisfied with their jobs (apart from discrimination) and whether discrimination seeped into other aspects of their job, diminishing job satisfaction. Discrimination experienced by the RNs was analysed using Feagin and Eckberg's Typology of Discrimination (1985). The analytical frameworks used as well as implications for future research will be discussed in this section.

The purpose of the study was to inform hospitals and health centres so they are aware of the issues that need to be addressed and the questions that need to be asked in order to identify and overcome discrimination at the workplace. Trends and policies on the national level as well as action that can be taken at the institutional levels will conclude this section.

6.1. Analytical Frameworks

Spector's nine facets of job satisfaction (Spector, 1985) addressed nine important factors of job satisfaction which included salary, nature of the work, working conditions, good relationships and communication at the workplace, appreciation and recognition, job supervision, and job security. Using this framework, the study excluded contextual factors that affect job satisfaction, such as the location of the workplace (e.g., capital city, urban, rural), and community fit. While Spector's (1985) nine facets of job satisfaction cover a range

of important factors associated with job satisfaction, it is, nevertheless, not an exhaustive and comprehensive list. Factors that influence job satisfaction include personal and contextual factors. Personal factors that affect job satisfaction include age, depression, anxiety and years of working experience. Contextual factors influencing job satisfaction include organisational commitment, occupational type (psychiatric or general) and team building skills by managers (Lu et al., 2005). In this study, earlier interviews conducted by the author highlighted personal factors that influenced job satisfaction such as familial ties, life satisfaction and physical health. Contextual factors that were mentioned included the attitude of colleagues and supervisors. Due to the narrowing of the scope of the study, these factors are not discussed here. Further research into the area of job satisfaction among migrant RNs in Finland is warranted to get a better picture of the factors at play.

The nurses interviewed seemed to find salary a non-issue in terms of job satisfaction. The findings from the study here show that while Spector's job satisfaction does contribute, it does not provide a complete and holistic view of all the factors that affect job satisfaction. Culture and language are important determinants when assessing cross-cultural scale meanings (Liu, Borg & Spector, 2004). Further research is needed to get a better understanding of all the factors that relate to job satisfaction among migrant RNs in Finland.

The other framework used in this study was **Feagin and Eckberg's Typology of Discrimination** (1985). Overall, the Typology of Discrimination was a good fit for this study, as it broke down discrimination into the four different ways in which it could manifest, namely, isolate discrimination (Type A), small group discrimination (Type B), direct discrimination (Type C) and indirect discrimination (Type D). Whether discrimination was affected on an individual or organizational level showed the embeddedness of the problem.

Institutional discrimination, Type C and Type D, were difficult to prove due to the legal wording of the laws on discrimination (The Employment Contracts Act, the Non-Discrimination Act 1325/2014, and the Criminal Code 39/1889.) Equal treatment of employees does not automatically translate into equal benefits and similar terms of employment, merely that discrimination is not allowed based on a number of factors, including ethnicity, language, and nationality (Anti-discrimination Laws in Finland, 2016). When complains of discrimination were not dealt with in a transparent fashion and opportunities for job promotion were at the discretion of head nurses, intentional discrimination was hard to prove. Furthermore, the fact that discrimination is illegal in Finland under The Employment Contracts Act, the Non-Discrimination Act 1325/2014, and the Criminal Code 39/1889 makes it difficult to tackle institutional discrimination. The legal environment does not encourage a thorough and critical evaluation of the implementation of non-discriminatory policies and procedures, which have severe legal consequences for non-compliance.

Although all the nurses in this study expressed overall satisfaction with their nursing worklife, they also all experienced discrimination in their workplace. This study clearly shows that despite a legal framework in place to discourage discrimination, it still exists on both the personal and institutional level in Finland. According to Shields and Price (2002), racial harassment decreases with age, with those in the age group of 35-44 reporting the highest incidences of racial harassment. Coincidentally, the youngest and the oldest nurse in this study reported the most discrimination. Married nurses and those with a higher level of education also reported a higher incidence of racial harassment from their colleagues (Shields and Price, 2002). This study showed that the two nurses working in the capital city of Helsinki did not experience personal or indirect institutional discrimination. Whether nurses

working in urban and rural areas experience working life and discrimination in Finland differently is a topic that merits further attention.

6.2 Trends and Policies

The Global North is facing a shortage of healthcare personnel and among them, RNs. An aging nursing workforce, in line with an aging population, is part of the reason for this. Low birthrates and an increase in life expectancy are remodeling the age pyramid of Europe towards a top heavy structure, indicating an older and aging population with a smaller younger, working age population to support them (Population structure and aging, 2018). According to the Ministry of Employment and Economics in Finland, 32% of the healthcare personnel will be retiring by 2020. This figure is expected to increase to 47% by 2025. (International Mobility of Healthcare and Social, 2012). An older, aging population needs more care and services, demanding more from the healthcare sector, including an increased demand for nurses. In an ironic twist, more is expected from an already shrinking group of professionals, leading to stress, early retirement or a complete change in career of existing nurses (Goodare, 2017).

While the local population might be getting older and shrinking in the Global North, overall population could still grow due to net migration. Between international education and mobile workplaces, wars and bombings, international migration has increased significantly in the current millennium. According to United Nations' latest study, there were 244 million international migrants in 2015, including 20 million refugees. The number of international migrants has increased by an astounding 41% in just 15 years since the year 2000.

International migration is now part of our economies and societies, bringing with it benefits

to both the host country and the country of origin, if managed properly (“244 million international migrants”, 2016). In 2015, 20,709 first residence permits were issued to migrants in Finland. Out of this, a little over half were issued for study and work purposes: 5,869 were issued for study purposes while 5,436 were issued for work purposes (“Just over 20,000 residence permits granted,” 2016).

Despite this, retaining skilled foreign labour, including RNs, in Finland has proven difficult. The reality is there is a considerable gap between national level policies and implementation of these policies in hospitals and hospital-like health centres. There is a gap in the actual behaviour of nurses and nurse leaders compared to what the policies designed seem to envisage. An unfavourable attitude towards the migrant RN could arise due to a lack of knowledge of a number of things. It could be due to a lack of knowledge of the English syllabus of nursing offered in the local universities of applied sciences, which complies with all the required requisitions of Finnish nursing regulations as well as the European Union (EU) requirements. It could also be due to a lack of awareness of the issue of discrimination and what comprises discrimination and racial harassment in the workplace. The importance of role models can also be employed to eradicate workplace discrimination of migrant RNs. Intentional commitment is needed for successful implementation of national policies calling for an end to workplace discrimination.

6.3 Institutional Level Actions

A number of actions can be taken on the institutional level to combat racism and discriminatory practices against migrant RNs. Cultural sensitivity and interpersonal skills training could be conducted in the workplace in an effort to combat workplace discrimination of migrant nurses. These skills would help nurses and healthcare personnel better understand

the challenges facing multicultural workplaces as well as highlight the benefits that could accrue from this if such a workforce is well managed. It could also highlight the cultural norms of minority nurses and give a better understanding to local nurses about certain habits and behaviours that might seem to be at odds with the dominant culture. This would help reduce cross-cultural misunderstandings as well as promote positive cross-cultural working relationships (Trennery, Franklin & Paradies, 2012).

Including questions on discrimination in the annual worker evaluation form would be another way to address discrimination at the workplace on hospitals and hospital-like settings.

Questions on discrimination should pertain to both discrimination experienced as well as witnessed. According to Low, Radhakrishnan, Schneider and Rounds (2007), first-hand knowledge that a co-worker had experienced racial harassment was itself detrimental to well-being. Knowledge of any sort of the racial harassment of others was also shown to have negative effects on the persons with such knowledge. As such, racial harassment in hospitals and hospital-like settings could be seen as not just detrimental to the migrant RN but to all healthcare personnel in that institution.

Anti-discriminatory practices should be incorporated into the workplace to discourage discrimination. Policies and procedures to combat discrimination should be clearly articulated and disseminated. It is also important that these are not merely distributed by posters and notices but by ward nurses and other supervisors during a face to face contact session with the healthcare personnel. Dissemination of such information should occur on a regular basis and not as an one-off incidence. Head nurses and supervisors should themselves have had some training to identify discriminatory workplace practices and how to respond in an appropriate manner when these are encountered or brought to their attention (Trennery, Franklin & Paradies, 2012). Implementation of anti-discriminatory practices would help

bridge the gap between national level policies and the behaviour of individual nurses in combating discrimination in hospitals and hospital-like settings.

Discrimination of migrant RNs leads to a hostile and non-conducive atmosphere at the workplace and ultimately to adverse patient outcomes. Constant and unnecessary supervision of the migrant RN can lead to lowered self-esteem and nervousness at the workplace.

Microaggression aimed at the migrant RN further contributes to a hostile work environment.

Moreover, the knowledge of racial harassment and discrimination also leads to stress and adverse effects in other nurses, who themselves are not subjected to such treatment.

The eradication of discrimination would go a long way in promoting a conducive workplace for all nurses and ensuring patient safety.

CONCLUSIONS

This study set out to find whether discrimination of migrant RNs existed at the workplace and if it did, what kind of discrimination was experienced by these RNs. The study found that discrimination did exist and it existed on both the inter-personal level (microlevel discrimination) as well as at the institutional level (macrolevel discrimination).

Discrimination was also found to affect certain facets of job satisfaction among these migrant RNs, leading to a desire to emigrate or leave the profession altogether. The study further proposes ways to reduce discrimination of the migrant RN in hospital and hospital-like settings. Measures that could be taken include cultural sensitivity and interpersonal training, inclusion of questions in the annual worker evaluation form on discrimination experienced and witnessed, and the implementation of anti-discriminatory practices at the workplace.

The eradication of discrimination in hospitals and hospital-like settings would help promote a safe and secure environment not only for migrant nurses but all nurses and healthcare personnel. Such an environment would also ensure the highest quality of healthcare by maximising a diverse and healthy workforce to achieve safe patient care and patient satisfaction.

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APPENDICES

Appendix 1 Excerpt of Interview Questions

Could you tell me a little bit about yourself.

- do you have family here?
- what made you end up in Finland?
- how long have you lived here?

How would you rate your Finnish language skills? (oral, written, spoken)

- how often do you speak Finnish?
- how do you feel when you speak Finnish?
- what is the response you get when you speak Finnish? How does this make you feel?

How do you find the people you meet in your work environment?

- what do you think about their attitudes / habits / culture?
- how do you get along with them?

How do you feel about your racial / ethnic origins living in Finland?

- when do you feel most comfortable being yourself? Least comfortable being yourself?
- have you ever felt like you have to change to try to fit in? Can you give some example?
- how well do you feel you have assimilated or integrated to the culture here?

How well do you feel you have adapted to the Finnish way of life?

- why do you feel that way?
- what kind of positive cultural norms have you adopted from Finland?
- what aspects of Finnish lives do you find frustrating/ silly etc?
- do you feel you are accepted into Finnish society?

How well do you relate to the people around you? How well would you say they relate to you?

- how would you describe the atmosphere of the people you are surrounded by?
- does it feel like a (physically) safe environment?
- do you feel like you belong socially in such an environment?
- how does this make you feel?

How would you define the relationships you have acquired in Finland?

- do you have many friends here? Many Finnish friends?
- do you feel you can depend on these friends?

What kind of things do you find interesting / challenging in your personal life?

What kind of personal relationships do you think you would have forged in 5 years / 10 years time?

- what kind of prospects in your personal life do you see for yourself?
 - how do you plan to go about achieving that?
 - why do you want to do that?
- How does this make you feel?

How do you imagine your social life to be in Finland if you were to stay here for the next 20 - 40 years?

- how do you see yourself living out your retirement years in Finland?
- how do you see your family and friends in your life as you age here?
- what do you think about living in an old folks home in Finland when you are old?

How do you see yourself in 5 years time in the workplace in Finland? Is this a realistic view?

- 10 years time?
 - how do you plan to go about achieving that?
 - why do you want to do that?
- How does this make you feel?

How would you describe your current pace of work in terms of

- colleagues, promotion, internal politics, etc.?
- what do you find most rewarding about your work?
- what displeases you about your workplace?

What kind of things do you find interesting / challenging in your work environment?

What have you achieved so far in life (workwise) that you are satisfied with / proud of?

How do you think your clients and colleagues see your contribution to the workplace?

- how do you think your ideas and opinions are received?
- do you feel what you say makes a difference in your environment?
- how do you feel about expressing your feelings and opinions?
- how do you feel you are perceived when you do so?
- how does this (imagined) perception of others regarding you make you feel?

Do you feel what you do makes a significant contribution towards your society?

- how well would you say you fit in there?
- are you proud of your contributions to society?
- do you feel appreciated / rewarded for your contributions?

How would you describe your life in Finland?

- how do you feel living in Finland?

What are the things that make you stressed?

- how often do you encounter these things?
- how do you cope with this?
- who do you turn to for help when you need someone to talk to / help you out?

In the course of a day, what kind of things do you feel grateful for that come your way?

- what kind of things inspire you in everyday life?
- do you feel inspired in your life?

How do you feel about your life at the moment?

What do you look forward to in life? (in Finland)